Department of Health Services WIC Supplemental Nutrition Branch

WIC REFERRAL FOR PREGNANT WOMAN

Health Care Provider:

Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits given program eligibility requirements must be most

WOMAN'S CURRENT (PRENATAL) Height ins Hemoglobin gm/dl Date last preg. ended Date last preg. ended Gravida Para	Patient's name (las		ility requirements must	Address (street, city, ZI	P)	Telephone number	Birthdate
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Measurement date and/or Blood set date Parts							
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PLEASE LIST ANY CURRENT MEDICAL CONDITIONS AFFECTIVO THIS WOMAN: Districts Multiple Pregnancy			Measurement date				
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MPRESSIONS/COMMENTS: Collect current or historical conditions (specify):				+PPD INH			
Other current or historical conditions (specify):	☐ Previous poo	or pregnancy ou	come/history (specify):				
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Telephone Number: MPORTANT: Must be signed by health care provider Date							
The United States Department of Agriculture (USDA) prohibits discrimination in its programs on the basis of race, color, national origin, gender, religion, age, disability, political belief sexual orientation, or marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (votce and TDD). To file a complaint of discrimination, write to USD Discotto, Office of Civil Rights, Room 256-W, Whitein Building, 14th and Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice and TDD). USDA an equal opportunity provider and employer. WIC REFERRAL FOR PREGNANT WOMAN State of California—Health and Human Services Agency WIC REFERRAL FOR PREGNANT WOMAN WIC Supplemental Nurrition Branch Health Care Provider: Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and to provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Program benefits since program eligibility requirements must be met. WOMAN'S CURRENT (PRENATAL) Height	LOCAL WIC AGEN	NCY			Name of physician/health care provider,	group/clinic	
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sexual orientation, or marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audio tape, etc.) should contact USDA's TARGET Center at (2027) 720-2609 (voic and TDD). To file a complain of discrimination, write to USD. Director, Office of Civil Rights, Room 326-W, Whitten Building, 14th and Independence Avenue, SW, Washington, DC, 20250-9410 or call (202) 720-5964 (voice and TDD). USDA an equal opportunity provider and employer. **WIC REFERRAL FOR PREGNANT WOMAN** **WIC Supplemental Nutrition Brant** **WIC REFERRAL FOR PREGNANT WOMAN** **WIC Supplemental Nutrition Brant** **WIC Supplemental Nutrition Brant** **Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status at provide nutritional counseling. An incomplete referral may delay program benefits to your patient. A completed referral does not guarantee WIC Progrational Englishing the program eligibility requirements must be met. **Patient's name (last, first)** **WOMAN'S CURRENT (PRENATAL)** **Height ins / Hemosophin gm/dl Date last preg. ended / **Date last preg. ended							
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Measurement date and/or Blood test date Gravida Para Weight lbs. Hematocrit % Pregravid weight lb PLEASE INDICATE ANY MEDICAL CONDITIONS AFFECTING THIS WOMAN: Diabetes Multiple Pregnancy Hypertension Tuberculosis +PPD INH Previous poor pregnancy outcome/history (specify): IMPRESSIONS/COMMENTS: Other current or historical conditions (specify): Telephone Number:	Hoight	inc		Homoglobin	am/dl		//
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IMPORTANT: Must be signed by health care provider Date			come/history (specify):		Name of physician/health care provider.	group/clinic	
			come/history (specify):		Name of physician/health care provider. Telephone Number:		

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WIC REFERRAL FOR POSTPARTUM/BREASTFEEDING WOMAN

Health Care Provider:

Please provide the information requested below for your patient. This information will be used by our program staff to assess your patient's health status and

)	Address (street, city, ZIP code	e)	Telephone number	Birthdate
WOMAN'S CURRENT (A	After Delivery)		PREGNANCY O	OUTCOME	/
Height	ins.	Preterm (27 who			very date
Weight	lbs. Measurement date	Full-Term (37 wks.)) Age Loss Stillbir		D: 4. 1
Hemoglobin	gm/dl.	2.		Oex Birtir Weight	Birth length
and/or		Please describe any medical	conditions affecting the infant(s):	Sex Birth weight	Birth length
Hematocrit	% Blood test date				
PLEASE INDICATE ANY	Y MEDICAL CONDITIONS AFFECTING TH	IS WOMAN.	PLEASE LIST ANY CURRENT ME	DICATIONS/SUPPLEMENTS PRES	CRIBED:
C-Section	Other conditions occurring du	ring this pregnancy or delivery			
Diabetes	(specify):				
Hypertension			IMPRESSIONS/COMMENTS:		
Tuberculosis	Other current or historical med	dical conditions (specify):			
+PPDIN	NH				
LOCAL WIC AGENCY			Name of physician/health care provi	ider/group/clinic	
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			Telephone number:		
			IMPORTANT: Must be signed by he	ealth care provider	Date
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Health Care Provide the	der: e information requested below for	vour patient. This informa	RTUM/BREASTFEEDI	NG WOMAN gram staff to assess your p	Department of Health Service Supplemental Nutrition Branch attent's health status a
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IMPORTANT: Must be signed by health care provider